

Dr. \_\_\_\_\_

Date of Appt \_\_\_\_\_

Time \_\_\_\_\_

Dear Patient:

Please complete the enclosed questionnaire and bring it with you to the clinic on the day of your appointment.

The proper insurance authorization, and your medical history, including current medical records, and x-rays related to this visit are also necessary for your evaluation.

If you have any questions, please feel free to contact me at 813.974.2553

Thank you,

Janice McCaskill, CPFT

PULMONARY DISEASE  
UNIVERSITY OF SOUTH FLORIDA MEDICAL CENTER

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone No. \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Race \_\_\_\_\_ Social Security No. \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lb.

**Past Medical History**

Have you ever had or been told that you had any of the following?

If YES, please check:

**Childhood Illnesses**

- |  |  |
|--|--|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Mumps         |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Other         |

**Adult Illnesses**

- |  |  |
|--|--|
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Stroke or paralysis   |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Diabetes (sugar)      |
| <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Arthritis             |
| <input type="checkbox"/> Stomach ulcers        | <input type="checkbox"/> Gout                  |
| <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Thyroid disease       |
| <input type="checkbox"/> Cirrhosis             | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Colitis               | <input type="checkbox"/> Anemia (low blood)    |
| <input type="checkbox"/> Diverticulitis        | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Gallstones            | <input type="checkbox"/> Tuberculosis (TB)     |
| <input type="checkbox"/> Pancreatitis          | <input type="checkbox"/> Hay fever             |
| <input type="checkbox"/> Kidney stones         | <input type="checkbox"/> Pneumonia             |
| <input type="checkbox"/> Gonorrhea             | <input type="checkbox"/> Pleurisy (chest pain) |
| <input type="checkbox"/> Syphilis              | <input type="checkbox"/> Bronchitis            |
| <input type="checkbox"/> Nervous breakdown     | <input type="checkbox"/> Emphysema             |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Heart disease         |
| <input type="checkbox"/> Epilepsy (seizures)   | <input type="checkbox"/> Angina (chest pain)   |

**Hospitalizations**

Have you ever been hospitalized?      YES       NO

IF YES, please list the hospitalizations in order from first to last, giving the date and reason. Please include medical illnesses (heart disease, kidney disease, depression, nervous breakdown, etc.) and surgical illnesses (appendectomy, tonsillectomy, gallbladder surgery, etc.); also specifically any hospitalization(s) or surgery for chest, lung or heart disorders:

<u>Year</u>	<u>Reason</u>	<u>Year</u>	<u>Reason</u>
1) _____	_____	6) _____	_____
2) _____	_____	7) _____	_____
3) _____	_____	8) _____	_____
4) _____	_____	9) _____	_____

**Injuries**

Have you ever had a major injury?..... YES \_\_\_\_\_ NO \_\_\_\_\_

if YES, check below:

	YEAR
_____ Head injury .....	_____
_____ Eye injury .....	_____
_____ Neck injury .....	_____
_____ Back injury .....	_____
_____ Fracture of _____	_____
_____	_____
_____	_____
_____ Chest injury, such as fractured rib or spine.....	_____
_____	_____
_____	_____
_____ Automobile Injury .....	_____
_____ Gunshot wound.....	_____
_____ Other .....	_____
_____	_____
_____	_____

**Transfusions**

Have you ever received a blood transfusion? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, state the reason for the transfusion:

**Vaccinations**

If you have had any of the following, check and if possible give the date of the last vaccination or booster:

	YEAR
_____ Smallpox .....	_____
_____ Poliomyelitis (polio) .....	_____
_____ Tetanus vaccination (polio) .....	_____
_____ Influenza .....	_____
_____ Pneumococcal (pneumonia) .....	_____

**Medications**

Please list below all medications you now take or have taken in the past 6 months. Please include aspirin, laxatives, nerve pills, birth control pills, vitamins, sleeping pills, etc., whether they are prescription drugs or not:

	<b>Name (if known)</b>	<b>Reason taken</b>	<b>How often; If daily, how many a day</b>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

**Allergies**

Are you allergic to any medication or do you have any other allergies?

Yes  No  If YES, please list the agent to which you are allergic and state the type of reaction you experience:

Medication _____	Type of reaction _____
_____	_____
_____	_____
Other _____	_____
_____	_____

**Specific Pulmonary Symptoms**-Please answer the following questions:

**COUGH**

1. Do you **USUALLY** cough first thing in the morning?..... YES \_\_\_\_\_ NO \_\_\_\_\_
2. Do you **USUALLY** cough at other times during the day or night? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

If answer to 1 or 2 is YES, answer 3, 4, and 5. If both are No, proceed to next topic.

3. Do you cough on most days as much as three months of the year? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

4. How many years have you had this cough? \_\_\_\_\_

5. Do you cough more on any particular day of the week? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, which day? \_\_\_\_\_

### **PHLEGM, SPUTUM OR MUCUS**

1. Do you USUALLY bring up phlegm (sputum, mucus) from your chest first thing in the morning?

YES \_\_\_\_\_ NO \_\_\_\_\_

2. Do you USUALLY bring up phlegm (sputum, mucus) from your chest at other times in the morning?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. Do you bring up phlegm (sputum, mucus) from your chest on most days for as much as three months of the year?

YES \_\_\_\_\_ NO \_\_\_\_\_

4. For how many years have you raised phlegm (sputum, mucus) from your chest? \_\_\_\_\_

5. What is the usual color of the phlegm (sputum, mucus) you bring up from your chest?

Don't know \_\_\_\_\_ Clear \_\_\_\_\_ White \_\_\_\_\_ Yellow \_\_\_\_\_ Green \_\_\_\_\_

Other (give details) \_\_\_\_\_

### **HEMOPTYSIS**

1. Have you coughed up blood from your chest in the past 2 years? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

2. If YES, when, how many times, give details \_\_\_\_\_

\_\_\_\_\_

3. Did you have a chest x-ray..... YES \_\_\_\_\_ NO \_\_\_\_\_

### **WHEEZING, WHISTLING, CHEST TIGHTNESS**

1. Have you ever noticed any wheezing, whistling or tightness in your chest?

YES \_\_\_\_\_ NO \_\_\_\_\_ If NO, proceed to **BREATHLESSNESS**.

2. Which symptoms have you experienced?

Only wheezing and whistling \_\_\_\_\_ Only chest tightness \_\_\_\_\_ Both \_\_\_\_\_

3. At what age did your wheezing, whistling or chest tightness first occur? \_\_\_\_\_

4. When did the wheezing, whistling or tightness occur last? \_\_\_\_\_

5. How frequently have you experienced this wheezing, whistling or chest tightness? Daily \_\_\_\_\_ Nightly \_\_\_\_\_

Few times a week \_\_\_\_\_ Few times a month \_\_\_\_\_ Few times a year \_\_\_\_\_ Only rarely \_\_\_\_\_

6. Is your wheezing, whistling or chest tightness brought on or made worse by exposure to; House Dust \_\_\_\_\_  
Other dusts or fumes at home \_\_\_\_\_ Contact with animals \_\_\_\_\_ Contact with plants or pollen \_\_\_\_\_  
Dusts, gases, or fumes at work \_\_\_\_\_ Tobacco smoke \_\_\_\_\_ Other \_\_\_\_\_

7. Is your wheezing, whistling or chest tightness worse on any particular day of the week?

YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, what day or days? \_\_\_\_\_

Do you always have it on Mondays? YES \_\_\_\_\_ NO \_\_\_\_\_

8. Is your wheezing, whistling or chest tightness worse:

a. Before work \_\_\_\_\_

b. After beginning work \_\_\_\_\_

c. With exercise \_\_\_\_\_

d. At night or when away from work \_\_\_\_\_

If symptoms are worse after beginning work, how many hours after beginning the shift? \_\_\_\_\_ and how long do symptoms last? \_\_\_\_\_

9. Are you allergic to anything? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, what? \_\_\_\_\_

10. After a week or more away from work, do you notice any change of breathing after return to work? \_\_\_\_\_

## **BREATHLESSNESS**

1. Are you disabled by any condition other than lung disease which interferes with your walking?

YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, proceed to **CHEST ILLNESS**.

2. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. Do you notice shortness of breath walking with other people of your own age on level ground?

YES \_\_\_\_\_ NO \_\_\_\_\_

4. Do you have to stop for breath when walking at your own pace on level ground?

YES \_\_\_\_\_ NO \_\_\_\_\_

5. Are you short of breath when washing or dressing? YES \_\_\_\_\_ NO \_\_\_\_\_

6. Are you short of breath at rest? YES \_\_\_\_\_ NO \_\_\_\_\_

7. Is your shortness of breath worse on Mondays? YES \_\_\_\_\_ NO \_\_\_\_\_

## CHEST ILLNESS

1. During the past 3 years have you had chest colds, bronchitis, or pneumonia?

None \_\_\_\_\_ 2 or 3 bouts \_\_\_\_\_ More than 3 bouts \_\_\_\_\_

2. During the past 3 years have any of these kept you off work or in bed for as long as a week?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. When was your last cold? \_\_\_\_\_

## TOBACCO SMOKING

1. Have you ever smoked tobacco? YES \_\_\_\_\_ NO \_\_\_\_\_

If NO, skip to **THE NEXT PAGE**

2. Have you ever smoked cigars regularly? YES \_\_\_\_\_ NO \_\_\_\_\_

a. How many years? \_\_\_\_\_ b. How many cigars per day? \_\_\_\_\_

c. Do you still smoke cigars? YES \_\_\_\_\_ NO \_\_\_\_\_

d. Do you (did you) inhale? YES \_\_\_\_\_ NO \_\_\_\_\_

3. Have you ever smoked a pipe regularly? YES \_\_\_\_\_ NO \_\_\_\_\_

a. How many years? \_\_\_\_\_ b. How many pipefuls a day? \_\_\_\_\_

c. Do you still smoke a pipe? YES \_\_\_\_\_ NO \_\_\_\_\_

d. Do you (did you) inhale? YES \_\_\_\_\_ NO \_\_\_\_\_

4. Have you ever smoked cigarettes? YES \_\_\_\_\_ NO \_\_\_\_\_

5. During your total years of cigarette smoking, what is the average number of packs of cigarettes you smoked each day? \_\_\_\_\_

6. How many total years have you smoked cigarettes? \_\_\_\_\_

7. Have you stopped smoking? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, how long has it been since you stopped smoking

a. \_\_\_\_\_ months b. \_\_\_\_\_ years.

**ALCOHOL**

Have you ever used alcoholic beverages?..... YES \_\_\_\_\_ NO \_\_\_\_\_

If YES. check below:

\_\_\_\_\_ none for \_\_\_\_\_ years.

\_\_\_\_\_ at present.

\_\_\_\_\_ socially only      \_\_\_\_\_ daily      \_\_\_\_\_ to excess on occasions.

**HOBBY AND LEISURE HISTORY**

Do you have contact with animals in your home?.....YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, check below:

\_\_\_\_\_ birds

\_\_\_\_\_ dogs

\_\_\_\_\_ cats

\_\_\_\_\_ other

Do you have other hobbies in which you may inhale fumes or dust? .....YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, please give details \_\_\_\_\_

**OCCUPATIONAL HISTORY:**

Check one or more:

\_\_\_\_\_ self-employed

\_\_\_\_\_ housewife

\_\_\_\_\_ employed (by others)

\_\_\_\_\_ student

\_\_\_\_\_ retired

\_\_\_\_\_ unemployed

If employed or self employed, describe the type of work: \_\_\_\_\_

Please list below all previous occupations from your first job to your current job:



Have you ever worked at any of the following occupations ..... YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, check and indicate how long:

\_\_\_\_\_ in a foundry ..... how long? \_\_\_\_\_

\_\_\_\_\_ in a coal mine .....how long? \_\_\_\_\_

\_\_\_\_\_ in any other mine; list the type ..... how long? \_\_\_\_\_

\_\_\_\_\_ in a quarry..... how long? \_\_\_\_\_

\_\_\_\_\_ in a pottery.....how long? \_\_\_\_\_

\_\_\_\_\_ in a cotton, flax or hemp mill ..... how long? \_\_\_\_\_

\_\_\_\_\_ as a tunnel worker .....how long? \_\_\_\_\_

\_\_\_\_\_ as a rock cutter.....how long? \_\_\_\_\_

\_\_\_\_\_ in manufacturing beryllium.....how long? \_\_\_\_\_

\_\_\_\_\_ in manufacturing ceramics, glass or abrasives.....how long? \_\_\_\_\_

\_\_\_\_\_ in any other job with exposure to dust, gas or fumes.....how long? \_\_\_\_\_

Describe the job \_\_\_\_\_

**EDUCATION**

Circle year completed:

Grade school                    1      2      3      4      5      6      7      8

High school                    1      2      3      4

College                        1      2      3      4

Other                            \_\_\_\_\_

**FAMILY HISTORY:**

Please check and describe where appropriate:

**Father**

\_\_\_\_\_ living            age \_\_\_\_\_            illnesses \_\_\_\_\_

\_\_\_\_\_ dead            age at death \_\_\_\_\_            cause \_\_\_\_\_

**Mother**

\_\_\_\_\_ living      age \_\_\_\_\_      illnesses \_\_\_\_\_  
\_\_\_\_\_ dead      age at death \_\_\_\_\_      cause \_\_\_\_\_

**Brothers and Sisters**

\_\_\_\_\_ living      age \_\_\_\_\_      illnesses \_\_\_\_\_  
\_\_\_\_\_ living      age \_\_\_\_\_      illnesses \_\_\_\_\_  
\_\_\_\_\_ living      age \_\_\_\_\_      illnesses \_\_\_\_\_  
\_\_\_\_\_ living      age \_\_\_\_\_      illnesses \_\_\_\_\_  
\_\_\_\_\_ dead      age at death \_\_\_\_\_      cause \_\_\_\_\_  
\_\_\_\_\_ dead      age at death \_\_\_\_\_      cause \_\_\_\_\_  
\_\_\_\_\_ dead      age at death \_\_\_\_\_      cause \_\_\_\_\_  
\_\_\_\_\_ dead      age at death \_\_\_\_\_      cause \_\_\_\_\_

If any of your blood relatives have had the following conditions, check and indicate their relationship to you:

\_\_\_\_\_ asthma      \_\_\_\_\_  
\_\_\_\_\_ emphysema      \_\_\_\_\_  
\_\_\_\_\_ bronchitis      \_\_\_\_\_  
\_\_\_\_\_ tuberculosis      \_\_\_\_\_  
\_\_\_\_\_ diabetes      \_\_\_\_\_  
\_\_\_\_\_ heart disease      \_\_\_\_\_  
\_\_\_\_\_ high blood pressure      \_\_\_\_\_  
\_\_\_\_\_ stroke      \_\_\_\_\_  
\_\_\_\_\_ arthritis      \_\_\_\_\_  
\_\_\_\_\_ gout      \_\_\_\_\_  
\_\_\_\_\_ epilepsy (seizures)      \_\_\_\_\_  
\_\_\_\_\_ cancer      \_\_\_\_\_  
\_\_\_\_\_ other      \_\_\_\_\_

## REVIEW OF SYSTEMS

### Weight

Present \_\_\_\_\_ Usual \_\_\_\_\_  
Any weight change in the past year? YES \_\_\_\_\_ NO \_\_\_\_\_

### Skin

\_\_\_\_\_ chronic or recurring skin condition  
\_\_\_\_\_ lump or growth on skin  
\_\_\_\_\_ change in color of skin

### Eyes

\_\_\_\_\_ glasses  
\_\_\_\_\_ decreased vision  
\_\_\_\_\_ pain in eyes

### Ears

\_\_\_\_\_ difficulty hearing  
\_\_\_\_\_ earaches  
\_\_\_\_\_ discharge from ears  
\_\_\_\_\_ buzzing or ringing in ears

### Nose and throat

\_\_\_\_\_ frequent sneezing  
\_\_\_\_\_ nose continually stuffed or runny  
\_\_\_\_\_ recurrent sore throats; persistent hoarseness

### Cardiopulmonary

\_\_\_\_\_ chest pain  
\_\_\_\_\_ shortness of breath cough  
\_\_\_\_\_ bloody sputum  
\_\_\_\_\_ wheezing  
\_\_\_\_\_ unusual heart beat

### Gastrointestinal

\_\_\_\_\_ frequent heartburn or indigestion  
\_\_\_\_\_ nausea or vomiting  
\_\_\_\_\_ stomach pain  
\_\_\_\_\_ diarrhea  
\_\_\_\_\_ constipation  
\_\_\_\_\_ blood in stool

### Genitourinary

\_\_\_\_\_ painful urination  
\_\_\_\_\_ frequent urination  
\_\_\_\_\_ bloody urine  
\_\_\_\_\_ discharge (penile or vaginal)

Musculoskeletal

- \_\_\_\_\_ painful joints
- \_\_\_\_\_ sore muscles
- \_\_\_\_\_ back pain

Neuropsychiatric

- \_\_\_\_\_ frequent or severe headaches
- \_\_\_\_\_ dizziness or faintness
- \_\_\_\_\_ more nervous than average person

For Women Only

- \_\_\_\_\_ periods irregular
- \_\_\_\_\_ bleeding between periods
- Date last menstrual period \_\_\_\_\_

Please check below if you have had any of the following in the past two years and indicate the date:

- \_\_\_\_\_ complete medical examination \_\_\_\_\_
- \_\_\_\_\_ electrocardiogram \_\_\_\_\_
- \_\_\_\_\_ blood count \_\_\_\_\_
- \_\_\_\_\_ blood chemistries \_\_\_\_\_
- \_\_\_\_\_ urinalysis \_\_\_\_\_
- \_\_\_\_\_ chest x-ray \_\_\_\_\_
- \_\_\_\_\_ pulmonary function tests (breathing test) \_\_\_\_\_

Were you referred by a physician? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, give his/her name and address:

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Name \_\_\_\_\_ SS# \_\_\_\_\_

Medication \_\_\_\_\_

Do you feel (better, worse, the same) with this medication?

Does your chest feel (better, worse, the same) with this medication?

Does your breath feel (better, worse, the same) with this medication? Can you do (more, less, the same) on this medication?

Do you have (more, less, the same) shortness of breath with this medication? If you had wheezing or chest tightness, is it (better, worse, the same)?

Do you cough (more, less, the same) on this medication?

Has the character of the cough changed (intensity, duration, time of day or night)?

Has your sputum changed (thinner, thicker, same)? Is your sputum (easier, harder, the same) to raise?

Do you have (more, less, the same) number of colds? Have you changed your smoking habits? (Give details)

Do you (always, usually, rarely, never) take your medications?

Do you have any side effects from this medication?

Headache	_____	Rapid heartbeat	_____
Dizziness	_____	Sweating	_____
Fainting	_____	Nausea	_____
Fatigue	_____	Vomiting	_____
Insomnia	_____	Indigestion	_____
Tremor	_____	Diarrhea	_____
Nervousness	_____	Constipation	_____
Anxiety	_____	Trouble Urinating	_____
Palpitations	_____	Impotence	_____
(Heart skipping)	_____	Other	_____

Physician: See reverse side of this sheet for physical examination information.

For Physician's Use  
PHYSICAL EXAMINATION